LAKE COUNTY
Board of County Commissioners

ES-5.02.01
Procedure

SUBJECT: Workers' Compensation Program

APPROVED: December 11, 2006

EXPIRATION DATE: This procedure remains in effect until superseded or cancelled.

SUPERSEDES: Policies and Practices Employee Manual, Section 24 and Section 25

ORIGINATOR: Employee Services

PURPOSE & SCOPE:
The purpose of this document is to provide procedures for reporting injuries and/or illnesses and obtaining treatment.

REFERENCES:
Florida Workers' Compensation Law, F. S. Chapter 440
Workers' Compensation and Property & Liability Policy (LCC-71)

APPLICABILITY:
This procedure applies to all employees of Lake County Board of County Commissioners (BCC) and employees from other Lake County agencies covered by the County's Workers' Compensation Program.

PROCEDURE:
During a Workers' Compensation claim, it is important that the manager/supervisor, employee, case manager, and the third party administrator communicate with one another to ensure that the Lake County employee who has experienced an on-the-job injury or illness returns to their normal job duties as soon as possible. The Office of Employee Services is available to answer questions or provide guidance concerning Workers' Compensation procedures.

1. Responsibilities

   A. Employee - All Lake County employees are required to immediately report on-the-job injuries and/or illnesses to their immediate supervisor.

   B. Management/Supervisory - Supervisors are responsible to ensure all necessary Workers' Compensation reports are signed, completed, faxed when necessary, collected and submitted as a complete packet to the Office of Employee Services immediately following an incident. These reports include the State of Florida's required First Report of Injury or Illness form and Lake County's Injury/Illness Reports. Lake County's Injury/Illness Reports include the Supervisor Investigation, Employee Statement, and Witness Statement forms. (*More information regarding the reporting requirements and forms are located in Section 7, Attachment 6 and on the Employees Services – Workers' Compensation webpage*.)

   C. Service Providers - The Third Party Administrator (TPA) will conduct investigations to gather information, obtain statements, communicate with injured employees and their supervisors, and when necessary negotiate settlements.

Lake County's managed healthcare company's Case Manager will coordinate the Workers' Compensation medical care of employees. Employees should contact the Case Manager whenever they have questions about their Workers' Compensation medical care. The Case Manager can be contacted twenty-four hours a day, seven days a week. The Office of Employee Services is available Monday through Friday, form 8:00 a.m. to 5:00 p.m. to answer questions or provide guidance concerning Workers' Compensation procedures.

2. Emergency Medical Treatment

A. The employee (or employee witness) will notify the supervisor as soon as possible if the injury/illness requires emergency medical treatment and is considered life-threatening.

B. In the event of a life-threatening injuries or illnesses, someone should call 911 immediately. Employees with life-threatening injuries or illnesses should be transported to an urgent care facility/hospital by ambulance. If employee is unable to communicate with the urgent care facility/hospital due to medical condition, supervisor and/or the Risk Coordinator will ensure all information is provided to the urgent care facility/hospital and the TPA. If unsure whether a medical condition is a life-threatening emergency, 911 should be called.

Examples of life-threatening injuries or illness include, but are not limited to:

1) Unconsciousness
2) Broken bones
3) Sudden dizziness or difficulty seeing
4) Severe abdominal pain
5) Trauma or injury to the head
6) Partial or total amputation of a limb or extremity
7) Persistent pain or discomfort in the chest or arms
8) Not breathing or having trouble breathing
9) No signs or lack of circulation
10) Severe bleeding
11) Seizures that are unusual, prolonged or multiple, last more than 5 minutes, result in injury or occur in someone who is pregnant or diabetic
12) Drug overdose
13) Eye injuries
14) Gunshot, knife or other weapons wound
15) Accidents such as falls or involving motor vehicles
16) High fever (greater than 101°F) with a severe headache and a stiff neck

C. The 911 calls should include:

1) The address and/or location of the emergency;
2) The telephone number where the emergency is located;
3) A brief description of the problem including whether the person(s) is conscious and/or breathing; and
4) The name of the employee calling 911.

Once the 911 call has been made, the caller should remain on the line to respond to questions from the 911 operator, if necessary.

D. If possible, the supervisor will provide a First Report of Injury or Illness to the employee and/or ambulance crew to present to the urgent care facility/hospital and pharmacy. Questions regarding treatment or prescriptions should be directed to the managed healthcare company's Case Manager. If employee is unable to communicate with the Case Manager due to medical condition, supervisor and/or the Risk Coordinator will ensure all reports are forwarded to the TPA.

E. As soon as possible following the emergency treatment, the employee must go to the authorized Workers' Compensation Healthcare Provider as required for continued Workers' Compensation coverage. The employee must provide the Healthcare Provider with a copy of the completed and signed First Report of Injury or Illness form, which serves as authorization for treatment.

3. Non-emergency Medical Treatment

A. If the injury/illness does not require emergency medical treatment and the injury/illness is not considered life threatening, the employee will notify the supervisor immediately. (If unsure whether a medical condition is a life-threatening emergency, 911 should be called.)

Examples of illnesses/injuries that may not be life-threatening include, but are not limited to:

1) Rashes
2) Upper respiratory infections
3) Sore throats
4) Earaches
5) Headaches
6) Abrasions
7) Lacerations
8) Flu like symptoms
9) Back pain
10) Sprains
11) Minor fractures

B. The supervisor will provide a First Report of Injury or illness to the employee to present to the Healthcare Provider and Pharmacy, if needed. The employee must provide the Healthcare Provider with a copy of the completed and signed First Report of Injury or Illness form, which serves as authorization for treatment.

C. Questions should be directed to Lake County's managed healthcare company's Case Manager.

D. The employee must use the authorized Healthcare Provider unless the injury/illness occurred after the Healthcare Provider's hours of operation.

E. If the injury/illness occurred after the Healthcare Provider's hours of operation, the employee should obtain medical treatment at the nearest urgent care facility/hospital. As soon as possible after treatment, the employee must go to the authorized Workers' Compensation Healthcare Provider as required for continued Workers' Compensation treatment. Questions regarding treatment or prescriptions should be directed to the managed healthcare company's Case Manager.

4. Healthcare Provider

Employees covered under Lake County's Workers' Compensation Program must go to Healthcare Provider authorized by the County, unless the injury/illness requires emergency treatment at an urgent care facility/hospital or the injury/illness occurs after the Healthcare Provider's hours of operation. Specific information such as hours of operation, contact numbers and location can be found on the Employee Services Workers' Compensation webpage. (*See Section 6*)

Medical treatment provided by an unauthorized Healthcare Provider may not be covered under the Lake County Workers' Compensation Program.

5. Workers' Compensation Reports

Workers' Compensation reports are easily obtained from the Lake County intranet, through the "Forms" Quick Link or by going to the Employee Services - Workers' Compensation webpage. (*See Section 6*)

Supervisors are responsible to ensure all reports are provided to employees and witnesses, completed, collected, and submitted as a complete packet to the Office of Employee Services immediately following an incident.

A. First Report of Injury or Illness *(Attachment 1)*

1) The supervisor and employee must complete the First Report of Injury or Illness immediately (or as soon as possible, if an emergency situation) after an injury/illness is reported.

2) The supervisor and employee must sign the original report and make a copy. The supervisor shall also provide the employee with a print out of the more specific information provided on the Employee Services – Workers' Compensation webpage.

3) The employee presents a copy of the report to the Urgent Care Facility or Healthcare Provider. This report serves as authorization for treatment.

4) The supervisor must fax the First Report of Injury or Illness report to the County's Workers' Compensation TPA.

5) The original/signed report shall be mailed through interoffice mail or hand delivered to the Offices of Employee Services, immediately following an incident.

6) This report is required by the state of Florida Department of Financial Services.

B. First Report of Injury or Illness – Report Only *(Attachment 2)*

This report is to be used by supervisors for employees who do not wish to seek medical treatment for the injury/illness, but still need to report the possible Workers' Compensation incident.

1) Supervisor and employee must complete the First Report of Injury or Illness (Report Only) immediately after an injury/illness is reported.

2) Supervisor and employee must sign the original report.

3) Employee elects not to have medical treatment.

4) Supervisor must fax the report to TPA.

5) The original/signed report shall be mailed through interoffice mail or hand delivered to the Offices of Employee Services, immediately following an incident.

6) Supervisor should also provide the employee with a copy of the specific information found on the Employee Services Workers' Compensation webpage.

7) This report is required by the state of Florida Department of Financial Services.

C. Supervisor is responsible to insure that the following respective Lake County reports are immediately completed after an injury/illness occurs and/or is reported:

1) Injury/Illness Report – Supervisor Investigation *(Attachment 3)*

2) Injury/Illness Report – Employee Statement *(Attachment 4)*

3) Incident Report – Witness Statement *(Attachment 5)*

The original/signed report(s) shall be mailed through interoffice mail or hand delivered to the Offices of Employee Services.

6. Workers' Compensation Webpage

The Employee Services Workers' Compensation webpage provides specific information and contact numbers for the County's Third Party Administrator, Healthcare Provider and Case Manager. The Office of Employee Services can also provide this information if necessary.

Supervisors should provide a print out of the specific information found on the Workers' Compensation webpage to the employee along with the First Report of Injury or Illness form. Supervisors should keep copies on hand that can be easily accessible in times of an emergency. Also, the Office of Employee Services will maintain copies for distribution.

To obtain this information, go to the Employee Services intranet/internet area and click on Workers' Compensation in the Related Links column, and print out the entire page.

7. On-the-Job Injury or Illness Flow Chart

   The On-the-Job Injury or Illness Flow Chart provides quick reference information on steps to take for emergency medical treatment, non-emergency medical treatment and no medical treatment procedures. (*Attachment 6*)

8. Light/Restricted Duty

   The supervisor will provide light duty work assignments to any employee on restrictions due to Workers' Compensation Physician recommendations.

   If the employee's department does not have a light duty work assignment, the supervisor should contact the Office of Employee Services. The Employee Services' Risk Coordinator will arrange with other departments for light duty assignments.

   Employees who refuse light duty work assignments will use their sick leave until released to regular work duty. If the employee exhausts sick leave while on light duty restriction and still refuses the light duty assignment, then the employee will begin using their accrued annual leave until released to regular work duty. If the employee has exhausted all accrued leave and still refuses light duty assignments, then the employee will go on a no pay status until the Workers' Compensation Physician releases them to regular work duty. All accrued leave must be exhausted before going into a no pay status.

   The employee will continue light duty work assignment until released by the Workers' Compensation Physician to return to regular work duties.

   If no light duty assignments exist within the County, the employee shall receive indemnity benefits under the Workers' Compensation program.

9. Compensation and Benefits

   An employee who is required to be absent from work due to an on-the-job injury/illness shall be compensated as follows:

   A. The employee's time sheet will be coded "CW" for the amount of time employee left work for medical treatment.

   B. The employee does not use sick leave for Workers' Compensation related doctor's appointments.

   C. The County will pay the employee for time taken for medical treatment if it is during their regularly scheduled work hours.

   D. Workers' Compensation does not pay for absences during the initial seven calendar days following an accident. The employee may choose to use accrued sick leave hours for the first 7 days, and as supplement pay to Workers' Compensation pay. Beginning the 8th day, the employee will begin receiving indemnity benefits of 66 & 2/3 of their average weekly wage. If the absence exceeds 21 calendar days, Workers' Compensation will pay the employee for the initial 7 days.

E. Worker's Compensation will pay compensation benefits for absences beyond the first seven calendar days in accordance with Florida Statutes Chapter 440.

F. County group benefits (health insurance, life insurance, etc.) shall continue so long as the employee remains in a pay status and in compliance with the eligibility requirements of the County and Workers' Compensation Program. If the employee goes into a no pay status, then the employee would have to make arrangement to pay the employee (their) portion of the County group benefits premiums until they return to full work status.

G. All available sick leave hours must be exhausted, before accrued annual leave may be used to supplement Workers' Compensation indemnity benefits.

H. Any leave associated with an on-the-job injury/illness (paid or unpaid), where the injury/illness is a "serious health condition" as defined in the Family and Medical Leave Act, shall be designated as Family Medical Leave (FMLA) and run concurrently with Workers' Compensation leave.

I. Employees are required to report their current work status to their supervisor, as determined by their physician (in writing) immediately following each office visit.

10. Safety Action Team

The Safety Action Team will review Injury/Illness reports at monthly meetings and make recommendations to reduce or eliminate future Workers' Compensation claims.

11. Further Investigation

Employee Services may require more information than the Workers' Compensation Reports provide. An investigation may be initiated if Employee Services deems it necessary, if the information contained in the report is contradictory or lacking in detail. An Employee Services representative will conduct an investigation to gather more information and make recommendations for preventing future claims and possible corrective actions.

RESERVATION OF AUTHORITY:
The Office of Employee Services is responsible for developing, implementing and updating policies and procedures supporting employment standards, programs and benefits as delegated by the Lake County Board of County Commissioners and the County Manager. The authority to issue and/or revise this procedure is reserved for the County Manager.

Approved By: Cindy Hall, County Manager
Date: 12/11/06

Attachment 1

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours
1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIM-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

Name (First, Middle, Last)	Social Security Number	Date of Accident	Time of Accident ☐ AM ☐ PM
Home Address Street/Apt. #: _____ City: _____ State: _____ Zip: _____	Employee's Description of Accident (Include Cause of Injury) (Select Cause of Accident)		
Telephone: Area Code Number			
Occupation: Date of Birth / Sex ☐ M ☐ F	Injury/Illness That Occurred (Select Nature of Injury)	Part of Body Affected (Select Body Part Description)	

EMPLOYER INFORMATION

Co. Name: **Lake County BOCC** D.B.A.: Street: **315 W. Main Street** City: **Tavares** State: **FL** Zip **32778**	Federal ID Number (FEIN) **596000695** Nature of Business **Government**	Date First Reported (Month/Day/Year)
Telephone: Area Code Number **1-352-343-9596**	Date Employed	Paid for Date of Injury ☐ Yes ☐ No
Employer's Location Address (if different) Street: City: State: Zip:	Last Date Employee Worked Returned to Work ☐ No If Yes, Give Date ☐ Yes	Will you continue to pay wages instead of Workers' Comp? ☐ Yes Last day wages will be paid instead of Worker's Comp. ____/____/____ Rate Of Pay ☐ HR ☐ WK $_____ Per ☐ DAY ☐ MO
Place of Accident (street, city, state, zip) Street: City: State: Zip: County of Accident:	Date of Death (if applicable) Agree with description of accident? ☐ Yes ☐ No	Number of hours per day Number of hours per week Number of days per week
Any person, who knowingly and with intent to injure, defraud, or deceive any employer or employee, Insurance Company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234. Section 440.105(7), F.S. Employee Signature (if available) Date Employer Signature Date		Name, Address Telephone and Fax of Physician or Hospital Authorized by Employer ☐ Yes ☐ No

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Case Denied - DWC-12, Notice of Denial Attached
☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached
☐ 2. Medical Only which became Lost Time Case (Complete all info in #3)
Employee's 8th Day of Disability _____/_____/_____
Entity's Knowledge of 8th Day of Disability _____/_____/_____
☐ 3. Lost Time Case -- 1st day of disability ___/___/___ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____

Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate_____

☐ T.T. ☐ T.T.-80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ Death ☐ Settlement Only

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

Remarks:			Insurer Name : Claims-Handling Entity Name, Address & Telephone
INSURER CODE # **9808**	Employee's Class Code	Employer's NAICS Code **921190**	**Employers Mutual, Inc** **700 Central Parkway** **Stuart, FL 34994** **Tele:1-800-431-2221 Fax: 1-772-220-1637**
Service Co/TPA Code # **6060**	Claims-Handling Entity File #		

Attachment 2

REPORT ONLY

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours
1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIM-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

Name (First, Middle, Last)	Social Security Number	Date of Accident	Time of Accident ☐ AM ☐ PM
Home Address Street/Apt. #: City: State: Zip:	Employee's Description of Accident (Include Cause of Injury) (Select Cause of Accident)		
Telephone: Area Code Number			
Occupation: Date of Birth / Sex ☐ M ☐ F	Injury/Illness That Occurred (Select Nature of Injury)	Part of Body Affected (Select Body Part Description)	

EMPLOYER INFORMATION

Co. Name: **Lake County BOCC** D.B.A.: Street: **315 W. Main Street** City: **Tavares** State: **FL** Zip **32778**	Federal ID Number (FEIN) **596000695**	Date First Reported (Month/Day/Year)
	Nature of Business **Government**	Policy/Member Number
Telephone: Area Code Number **1-352-343-9596**	Date Employed	Paid for Date of Injury ☐ Yes ☐ No
Employer's Location Address (if different) Street: City: State: Zip:	Last Date Employee Worked Returned to Work ☐ No If Yes, Give Date ☐ Yes	Will you continue to pay wages instead of Workers' Comp? ☐ Yes Last day wages will be paid instead of Worker's Comp. ___/___/___ Rate Of Pay ☐ HR ☐ WK $_____ Per ☐ DAY ☐ MO
Place of Accident (street, city, state, zip) Street: City: State: Zip: County of Accident:	Date of Death (if applicable) Agree with description of accident? ☐ Yes ☐ No	Number of hours per day Number of hours per week Number of days per week

Any person, who knowingly and with intent to injure, defraud, or deceive any employer or employee, Insurance Company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234. Section 440.105(7), F.S.

Employee Signature (if available) Date

Employer Signature Date

Name, Address Telephone and Fax of Physician or Hospital

Authorized by Employer ☐ Yes ☐ No

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Case Denied - DWC-12, Notice of Denial Attached
☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached
☐ 2. Medical Only which became Lost Time Case (Complete all info in #3)
Employee's 8th Day of Disability _____/_____/_____
Entity's Knowledge of 8th Day of Disability _____/_____/_____
☐ 3. Lost Time Case -- 1st day of disability ___/___/___ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____

Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate_____

☐ T.T. ☐ T.T.-80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ Death ☐ Settlement Only

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

Remarks:			Insurer Name : Claims-Handling Entity Name, Address & Telephone
INSURER CODE # **9808**	Employee's Class Code	Employer's NAICS Code **921190**	**Employers Mutual, Inc** **700 Central Parkway**
Service Co/TPA Code # **6060**	Claims-Handling Entity File #		**Stuart, FL 34994** **Tele:1-800-431-2221 Fax: 1-772-220-1637**

Attachment 3

Injury/Illness Report – *Supervisor Investigation*

Lake County Board of County Commissioners

Supervisor must complete this report **immediately** following the on-the-job injury/illness.

Report must include **FULL** details concerning the injury/illness incident.

Section I – Employee Information

Name of Employee	Department	Division	Job Title

Section II – Conditions/Facts

Date Reported	Time	Location of Incident	Supervisor Name	Supervisor Phone Number

Body Part Injured

☐ Head	☐ Eye	☐ Left	☐ Right
☐ Face	☐ Ear	☐ Left	☐ Right
☐ Neck	☐ Shoulder	☐ Left	☐ Right
☐ Back	☐ Arm	☐ Left	☐ Right
☐ Chest	☐ Elbow	☐ Left	☐ Right
☐ Lungs	☐ Wrist	☐ Left	☐ Right
☐ Abdomen	☐ Hand	☐ Left	☐ Right
☐ Groin	☐ Hip	☐ Left	☐ Right
☐ Foot	☐ Knee	☐ Left	☐ Right
☐ Ankle	☐ Leg	☐ Left	☐ Right
☐ Toe(s)	☐ Finger	☐ Body System	

Nature of Injury / Illness

☐ Abrasion	☐ Infectious Disease Exposure	☐ Open Wound	☐ Heat Stress
☐ Amputation	☐ Toxic Atmosphere Exposure	☐ Poisonous Bite	☐ Laceration
☐ Strain/Sprain	☐ Foreign Body	☐ Poisonous Plant	☐ Puncture
☐ Bruise	☐ Fracture	☐ Poisoning	☐ Vision Loss
☐ Burn	☐ Hearing Loss	☐ Cold Injury	
☐ Irritation	☐ Unconsciousness	☐ Cumulative Trauma	
☐ Dermatitis	☐ Multiple Injury	☐ Heart Attack	

☐ Other:

Gender: ☐ Male ☐ Female

Names of all Witnesses	

Specifically, describe the incident: How it occurred, what task was being done, for how long, with what equipment, at what pace, conditions at the site (e.g., sunny, slippery, indoors, etc.) Identify possible causes or factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) **Details are crucial for identifying primary cause of the incident.** *(If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)*

Supervisor Investigation & Primary Cause of Incident:

Section III – Preventative Action

What preventative action will eliminate/minimize the risk of this type of incident again? What would employee do to prevent incident? Examples: Written procedure, training, equipment change, corrective actions-warning/suspension to employee, etc.

Supervisor Preventative Action:

Section IV – Signatures

Supervisor Signature **Date** **Division Director Signature (If Applicable)** **Date**

Department Director Signature **Date**

Please attach Employee and Witness Statements, and submit reports as one packet to the Office of Employee Services, Administration Building, Rm. 430 / 315 W. Main St, Tavares, FL 32778.

Revised 11/29/06

Attachment 4

Injury/Illness Report – *Employee Statement*

Lake County Board of County Commissioners

Employee must complete this report **immediately** following the on-the-job injury/illness.
Report must include **FULL** details concerning the injury/illness incident.

Section I – Employee Information

Name of Employee	Phone Number	E-mail
Department	**Division**	**Job Title**

Date	Time	Location of Incident	Supervisor Name

Body Part Injured

☐ Head	☐ Eye	☐ Left	☐ Right
☐ Face	☐ Ear	☐ Left	☐ Right
☐ Neck	☐ Shoulder	☐ Left	☐ Right
☐ Back	☐ Arm	☐ Left	☐ Right
☐ Chest	☐ Elbow	☐ Left	☐ Right
☐ Lungs	☐ Wrist	☐ Left	☐ Right
☐ Abdomen	☐ Hand	☐ Left	☐ Right
☐ Groin	☐ Hip	☐ Left	☐ Right
☐ Foot	☐ Knee	☐ Left	☐ Right
☐ Ankle	☐ Leg	☐ Left	☐ Right
☐ Toe(s)	☐ Finger	☐ Body System	

Nature of Injury / Illness

☐ Abrasion	☐ Infectious Disease Exposure	☐ Open Wound	☐ Heat Stress
☐ Amputation	☐ Toxic Atmosphere Exposure	☐ Poisonous Bite	☐ Laceration
☐ Strain/Sprain	☐ Foreign Body	☐ Poisonous Plant	☐ Puncture
☐ Bruise	☐ Fracture	☐ Poisoning	☐ Vision Loss
☐ Burn	☐ Hearing Loss	☐ Cold Injury	
☐ Irritation	☐ Unconsciousness	☐ Cumulative Trauma	
☐ Dermatitis	☐ Multiple Injury	☐ Heart Attack	

☐ Other:

Gender: ☐ Male ☐ Female

Section II – Conditions/Facts

Specifically, describe the incident: How it occurred, what task was being done, for how long, with what equipment, at what pace, conditions at the site (e.g., sunny, slippery, indoors, etc.) Identify possible causes or factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) **Details are crucial for identifying primary cause of the incident.** *(If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)*

Employee Statement:

Section III – Signatures

Employee Signature **Date** **Supervisor Signature** **Date**

Attach report to Supervisor Investigation, and supervisor will send all reports to the Office of Employee Services, Administrative Building, Rm. 430 / 315 W. Main St, Tavares, FL 32778.

Revised 11/29/06

Attachment 5

Incident Report – *Witness Statement*

Lake County Board of County Commissioners

(This form can be used for workers' compensation and/or property & liability situations.)

Witness must complete this report **immediately** following the incident.

Report must include **FULL** details concerning the incident.

Section I – Witness Information

Name of Witness	Department of Witness	Phone Number of Witness

Section II – Conditions/Facts

Name of Employee involved in the Incident		Supervisor of Employee involved in the Incident
Date of Incident	**Time of Incident**	**Specific Location of Incident**

Specifically, describe the incident: How it occurred, what was our involvement, what was the employee doing (describe task being done), for how long, with what equipment, at what pace, conditions at the incident site (e.g., sunny, slippery, indoors, etc.) Identify possible causes/factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) **Details are crucial for processing and prevention.** *(If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)*

Witness Statement:

Section III – Signatures

Witness Signature **Date**

Attach report to Supervisor Investigation, and supervisor will send all reports to the Office of Employee Services, Administrative Building, Rm. 430 / 315 W. Main St, Tavares, FL 32778.

Revised 11/29/06

Attachment 6